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BIOETIKA

Ersun Augustinus KAYRA
Independent Catholic writer and researcher,
Istanbul, Turkey
Nepriklausomas katalikų rašytojas ir tyrėjas,
Stambulas, Turkija

Brain Death, Moral Certainty, and the Ethics of Organ Donation in Catholic Thought

SMEGENŲ MIRTIS, MORALINIS TIKRUMAS IR ORGANŲ DONORYSTĖS ETIKA PAGAL KATALIKŲ MOKYMĄ

SUMMARY. Organ donation is widely commended in Catholic teaching as a "noble and meritorious act" and a concrete expression of generous solidarity. Yet the practice of procuring vital organs from donors diagnosed dead by neurological criteria ("brain death") has come under renewed scrutiny. Developments in intensive care medicine, long-term maintenance of patients after a brain death diagnosis, and debates about residual hypothalamic and neuroendocrine function have raised questions about whether current standards of death determination secure the "moral certainty" required by Catholic moral theology. At the same time, donation after circulatory death (DCD) has been proposed as an alternative pathway that avoids some, but not all, of the contested issues around neurological criteria.

This article offers a Catholic theological reading of the contemporary brain death controversy. It proceeds by conceptual and document analysis of key magisterial texts (the Catechism of the Catholic Church, Evangelium vitae, papal addresses, and ecclesial guidelines) and of recent Catholic bioethical literature. It argues that: (1) organ donation remains, in principle, a paradigmatic form of Christian charity; (2) the Church has only provisionally accepted neurological criteria, and always under the condition that they truly track the death of the person; and (3) empirical and conceptual concerns about integrative unity make uncritical confidence in current protocols impossible.

Rather than calling for a blanket rejection of organ donation, the article proposes a path of "cautious generosity" that combines a renewed affirmation of donation with strengthened diagnostic standards, transparent communication, and robust protection of conscience.

SANTRAUKA. Organų donorystė katalikų mokyme plačiai vertinama kaip *kilnus ir nuopelningas veiksmas* bei konkretus dosnaus solidarumo pavyzdys. Tačiau praktika imti gyvybiškai svarbius organus iš donorų, kuriems pagal neurologinius kriterijus (pvz., smegenų mirtį) diagnozuota mirtis, vėl tapo kritikos objektu.

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Intensyviosios terapijos medicinos pažanga, ilgalaikė pacientų priežiūra po smegenų mirties diagnozės ir diskusijos apie likusią hipotalaminę ir neuroendokrininę funkciją kelia klausimų, ar dabartiniai mirties nustatymo standartai užtikrina katalikų moralės teologijos reikalaujamą *moralinį tikrumą*. Kaip alternatyva, leidžianti išvengti kai kurių, bet ne visų ginčytinų klausimų, susijusių su neurologiniais kriterijais, siūloma donorystė po negrįžtamai nutrūkusios kraujotakos (DNNK).

Šiame straipsnyje, remiantis Katalikų Bažnyčios mokymu, pateikiama šiuolaikinės smegenų mirties kontroversijos interpretacija, analizuojami pagrindiniai magisteriumo tekstai (Katalikų Bažnyčios katekizmas, enciklika *Evangelium vitae*, popiežių kreipimaisi ir bažnytinės gairės) bei naujausi darbai katalikų bioetikos tema. Juose teigiama, kad: 1) organų donorystė iš esmės lieka paradigminė krikščioniškos meilės forma; 2) Bažnyčia neurologinius kriterijus priima tik su sąlyga, kad jie tikrai atspindi asmens mirtį; 3) empiriniai ir konceptualūs susirūpinimai dėl integralios asmens vienybės neleidžia nekritiškai pasitikėti dabartiniais protokolais. Straipsnyje, užuot raginus visiškai atmesti organų donorystę, siūlomas *atsargaus dosnumo* variantas, kai pritariama donorystei remiantis sustiprintais diagnostikos standartais, skaidria komunikacija ir tvirta sąžinės apsauga.

KEYWORDS: organ donation, brain death, moral certainty, donation after circulatory death (DCD), Catholic bioethics.

RAKTAŽODŽIAI: organų donorystė, smegenų mirtis, moralinis tikrumas, donorystė po negrįžtamai nutrūkusios kraujotakos (DNNK), katalikų bioetika.

Introduction: A Gift Caught in Controversy

In contemporary hospitals, the scene has become familiar. A family stands at the bedside of a loved one on a ventilator while physicians speak of "brain death" and ask about organ donation. For some, this moment appears as a luminous possibility: in the midst of tragedy, the donor's body can become a gift that sustains several lives. For others, it feels like a precipice: Is he really dead? Are we giving life, or consenting to his killing?

Catholic teaching strongly encourages organ donation as an act of self-giving charity. At the same time, the determination of death by neurological criteria (DNC) has been increasingly contested. Case reports of prolonged somatic survival after a brain death diagnosis, the persistence of neuroendocrine functions, and legal debates over redefining death have sharpened the question of whether current criteria adequately express the reality of human death. Alongside this, donation after circulatory death (DCD) has re-emerged as an alternative pathway, itself not free of ethical difficulties.

This article explores these questions from within Catholic theology. It asks what moral certainty requires in the context of organ donation and proposes an ethic of cautious generosity that affirms donation while calling for reform and humility.

Aim and Methodology. The article does not attempt to resolve the medical details of death determination. Its aim is more modest and more theological: to ask what moral certainty requires in light of Catholic anthropology and magisterial teaching.

Methodologically, the article proceeds through three steps: (1) document analysis of key ecclesial texts (the Catechism, *Evangelium vitae*,[1] papal addresses, and episcopal guidelines); (2) conceptual analysis of "death", "integrative unity", and "moral certainty" as used in contemporary Catholic bioethics; and (3) principle-based ethical analysis, employing classical Catholic categories – respect for life, the option for the vulnerable, and conscience – to evaluate DNC and DCD. The goal is to articulate a framework of cautious generosity that can guide Catholic ethicists, pastors, and policy-makers.

1. Organ Donation in Catholic Teaching: Gift, Solidarity, and Limits

The starting point of Catholic reflection is unambiguously positive. The Catechism of the Catholic Church describes organ donation after death as a "noble and meritorious act" that should be encouraged as an expression of generous solidarity. Papal teaching presents organ transplantation as an important development in medicine's service of life and urges Christians to consider donation as a way in which their death can give life to others.[2]

This positive appraisal rests on a specific theological anthropology: the body is not a mere instrument of the self but an essential dimension of personal identity. Precisely as a "body-person", the human being can make a gift of his or her flesh. Donation, when freely chosen, becomes a participation in Christ's self-giving – "this is my body, given for you" – and in the communion of saints, where the lives of believers sustain one another.

1.1 Consent, Respect, and the Dead Body

Catholic teaching also draws clear boundaries. Organ removal requires the explicit and free consent of the donor or a legitimate surrogate. The body of the donor, living or dead, must never be treated as a warehouse of spare parts. After death, the corpse deserves reverence as the remains of someone made in the image of God; before death, the living body enjoys an inviolable dignity that excludes mutilation or killing as a means to any end, however beneficial.

These limits imply a crucial moral condition: vital organs may be removed only once the person is truly dead. Any procedure that intentionally causes the death of a living person – whether by removing vital organs or by hastening circulatory collapse in order to procure them – is intrinsically wrong. The Church's enthusiastic praise of organ donation always presupposes, therefore, a reliable determination of death.

[1] John Paul II, *Evangelium vitae (Encyclical Letter on the Value and Inviolability of Human Life)*, March 25, 1995, §86, accessed December 3, 2025, https://www.vatican.va/content/john-paul-ii/en/encyclicals/documents/hf_jp-ii_enc_25031995_evangelium-vitae.html.

[2] Catechism of the Catholic Church, 2nd ed. (Vatican City: Libreria Editrice Vaticana, 1997), no. 2296.

1.2 Moral Certainty as a Threshold

Catholic moral theology distinguishes metaphysical certainty from moral certainty. Moral certainty is the highest degree of certainty normally attainable in practical matters; it excludes reasonable doubt but does not require absolute proof. In his 2000 address to the Transplantation Society, John Paul II explicitly applied this distinction to organ donation, stating that physicians may proceed only when they have reached moral certainty that the donor is dead, on the basis of criteria generally accepted as corresponding to that fact.[3]

The Pope did not dogmatically define death in neurological terms, nor did he canonise a particular medical protocol. Instead, he conditionally accepted neurological criteria insofar as they provide the necessary moral certainty. He stressed that the Church does not make technical decisions about the parameters for ascertaining death, but rather compares the data of medical science with the Christian understanding of the person in order to identify both convergences and possible conflicts that might endanger human dignity. This conditional and comparative stance is key to understanding the Church's provisional acceptance of neurological criteria.

1.3 Presumed Consent and Opt-Out Systems

In several European jurisdictions, organ donation operates under presumed-consent or opt-out policies. Citizens are treated as potential donors unless they have registered an objection. Such policies are often defended as a pragmatic response to chronic organ shortages, but they also change the moral grammar of donation: the default shifts from an explicit gift to an assumed availability.[4]

From a Catholic perspective, this shift raises two linked concerns. First, it can weaken the requirement of free and informed consent by placing the burden of refusal on the citizen – especially those with limited health literacy, language barriers, or low institutional trust. These are not merely administrative concerns but questions of human dignity and justice. Second, in settings already marked by urgency and asymmetries of power, opt-out defaults can intensify systemic pressure on families and clinicians, making it harder to ensure that procurement pathways remain clearly separated from end-of-life decisions and from conflicts of interest.

A policy of presumed consent is not necessarily equivalent to coercion, but its moral acceptability depends on safeguards that honour the Church's emphasis on voluntariness, transparency, and protection of the vulnerable: easy and well-publicized

[3] John Paul II, "Address to the 18th International Congress of the Transplantation Society," August 29, 2000, Vatican website, accessed December 3, 2025, https://www.vatican.va/content/john-paul-ii/en/speeches/2000/jul-sep/documents/hf_jp-ii_spe_20000829_transplants.html.

[4] Catholic Bishops' Conference of England and Wales, "Presumed Consent – Organ Donation in Wales," July 1, 2013, accessed December 3, 2025, https://www.cbcew.org.uk/presumed-consent-organ-donation-in-wales/.

opt-out mechanisms ("soft opt-out" with family consultation), sustained public education, clear conscience protections, and independent oversight. Such safeguards are also required to sustain moral certainty about the donor's intention: a default presumption cannot, by itself, establish the moral clarity that Catholic ethics demands. Within the framework of "cautious generosity," Catholics can affirm donation as a work of charity while insisting that no institutional design should achieve higher donation rates by exploiting ignorance, marginalization, or moral uncertainty.[5]

2. Neurological Criteria, Integrative Unity, and the Brain Death Debate

The concept of "brain death" emerged in the late 1960s, most famously with the Harvard Ad Hoc Committee's report on "irreversible coma." The context was not only the first heart and kidney transplants, but also the rapid development of intensive care units and mechanical ventilation. These technologies created a new clinical situation: patients who would previously have died of respiratory failure could now be maintained for days or weeks with assisted ventilation, even after catastrophic brain injury.[6]

The standard integrationist rationale holds that the brain – particularly the brainstem – is the central organ coordinating respiration, circulation, and other vital functions. When all brain functions have irreversibly ceased, the organism as a whole can no longer act as a self-integrating unity. Brain death, on this view, is not merely a convenient label, but a valid sign of the death of the human organism.

This rationale is sometimes expressed in hylemorphic language: once the brain can no longer sustain the body as an "organism as a whole", the soul, as substantial form, can no longer inform the body. The loss of brain-mediated integration is thus taken to be the bodily side of the separation of soul and body.

2.1 Shewmon's Empirical Challenge

D. Alan Shewmon has challenged this consensus by compiling clinical cases in which patients diagnosed as brain dead exhibited prolonged somatic functioning: wound healing, temperature regulation, neuroendocrine activity, gestation of a fetus, and even growth and sexual maturation in children.[7] His analysis suggests that, at least in some

[5] See also Simon Doran, "Organ Donation and the Ars Moriendi," *Linacre Quarterly* 86, no. 4 (2019): 360–374, https://pmc.ncbi.nlm.nih.gov/articles/PMC6880080/.

[6] Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, "A Definition of Irreversible Coma," *Journal of the American Medical Association* 205, no. 6 (1968): 337–40, https://doi.org/10.1001/jama.1968.03140320031009.

[7] D. Alan Shewmon, "Chronic 'Brain Death': Meta-analysis and Conceptual Consequences," *Neurology* 51, no. 6 (1998): 1538–1545, https://doi.org/10.1212/WNL.51.6.1538.

cases, the organism retains a significant degree of holistic integration despite the irreversible loss of all clinically detectable brain function.[8]

Shewmon's point is not merely that organs continue to work, but that the body as a whole sometimes continues to coordinate complex processes over weeks or months. If integrative unity is the decisive sign of life, then these cases appear to show that the human organism can remain alive without a functioning brain.

2.2 Defenders' Reply: What Kind of Unity?

Defenders of neurological criteria have responded by refining the concept of integrative unity rather than abandoning it.[9] They argue that what matters is not any integrated biological activity, but the capacity of the organism to function as a single, self-governing whole in relation to its environment.

Several points are emphasised: dependence on artificial support – since brain dead patients who show prolonged somatic functioning invariably depend on mechanical ventilation and intensive care; the irreversible absence of spontaneous breathing as a decisive sign that the organism has lost the basic capacity to sustain itself; and the analogy to amputations and organ failure – an organism can survive the loss or failure of particular organs, but the complete and irreversible cessation of all brain function is presented as qualitatively different, because the brain is the only organ whose failure entails a loss of the organism's basic coordinating capacity.

From this perspective, Shewmon's cases demonstrate that complex integrated processes can be sustained in a body after brain death, but they do not show that such a body remains an organism as a whole in the relevant ontological sense. The debate then shifts from empirical data to philosophical interpretation: what exactly counts as evidence that the organism-as-a-whole no longer exists?

2.3 Integrative Unity and Catholic Anthropology

Here Catholic anthropology can help clarify the stakes. Drawing on Thomas Aquinas and the Council of Vienne, the Church teaches that the soul is the substantial form of the body: death occurs when the soul can no longer inform matter as a single, unified living organism. John Paul II describes death as a "single event" of "total disintegration of that unitary and integrated whole that is the personal self."

8 D. Alan Shewmon, "'Brain Death': A Valid Theme with Invalid Variations, Blurred by Semantic Ambiguity," in *The Determination of Brain Death and Its Relationship to Human Death: Proceedings of the Working Group 10–14 December 1989*, ed. R. J. White, H. Angstwurm, and I. Carrasco de Paula, Scripta Varia 83 (Vatican City: Pontifical Academy of Sciences, 1992), 23–51.

9 Melissa Moschella, "Deconstructing the Brain Disconnection–Brain Death Analogy and Clarifying the Rationale for the Neurological Criterion of Death," *Journal of Medicine and Philosophy* 41, no. 3 (2016): 279–299, https://doi.org/10.1093/jmp/jhw006.

Two points follow. First, death is one event, not a process: the soul does not gradually fade away but ceases to inform the body when the body can no longer exist as a unified living organism. Second, integrative unity is bodily evidence, not a metaphysical definition. Neither Aquinas nor the Council of Vienne identifies the brain as a privileged locus of the soul's activity. Integrative unity is a sign that the soul still informs the body, but it is not itself the soul. Catholic hylemorphism therefore does not automatically settle whether the loss of all brain function is sufficient to show that the soul has departed.

3. Donation after Circulatory Death: Promise and Peril

The controversy over brain death has led some ethicists and policy-makers to look more favourably on donation after circulatory death (DCD). In controlled DCD protocols, life-sustaining treatment is withdrawn from a patient with a very poor prognosis; when the heart stops and a specified no-touch interval passes without autoresuscitation – that is, the heart restarting on its own – death is declared on circulatory-respiratory grounds and organ retrieval begins.

From one angle, DCD seems closer to traditional understandings of death. The irreversible cessation of circulation and breathing was, for centuries, the ordinary sign that the person had died. On this basis, DCD – if carefully implemented and clearly separated from the decision to withdraw treatment – can appear more straightforward than DNC.

Other authors argue that this confidence is premature.[10] They contend that, in at least some DCD protocols, the no-touch interval may be too short to exclude the possibility of autoresuscitation or successful resuscitation, and that the desire to procure organs may exert subtle pressure on the timing of withdrawal of treatment. From this perspective, DCD can violate the dead donor rule just as seriously as ill-applied neurological criteria, because organs may be removed from donors who are not yet irreversibly dead.

Utilitarian Pressures and Deontological Limits. The ethical tension can be framed as a conflict between utilitarian and deontological reasoning. A utilitarian approach stresses outcomes: DCD opens up a significant pool of organs, reduces waiting list mortality, and appears to respect traditional signs of death. Some argue that the extremely low probability of autoresuscitation after a few minutes of asystole is morally acceptable in view of the many lives saved.

[10] Ari R. Joffe, John Carcillo, Allan de Caen, et al., "Donation after Cardiocirculatory Death: A Call for a Moratorium Pending Full Public Disclosure and Fully Informed Consent," *Philosophy, Ethics, and Humanities in Medicine* 6 (2011): 17, https://doi.org/10.1186/1747-5341-6-17.

A deontological – and specifically Catholic – approach insists that some acts, such as intentionally causing or risking the death of an innocent person, are intrinsically wrong, regardless of outcomes. If there remains a relevant risk that the donor is alive, the act of procurement itself may constitute an unjust killing, whatever the benefits. Catholic ethics, while acknowledging the importance of outcomes, must ultimately align with the latter approach: the inviolability of the innocent sets a moral boundary that cannot be crossed in the name of utility.

4. Magisterial Teaching and Catholic Reception

The magisterium has not promulgated a technical definition of death. It has, however, articulated binding principles: the inviolable dignity of every human person from conception to natural death; the obligation to avoid directly killing an innocent person; the nobility of organ donation as a form of charity; the need for free and informed consent; and the requirement of moral certainty before organ retrieval.

In his 2000 address to the Transplantation Society, John Paul II stresses that every medical procedure is subject not only to technical limits but also to limits set by respect for human nature, famously recalling that what is technically possible is not for that reason alone morally admissible. He praises organ donation as a gesture of love, yet insists that vital organs which occur singly can be removed only after death, that is, from the body of someone who is certainly dead.

With regard to brain-based criteria, he notes that the Church does not make technical decisions about the parameters for ascertaining death but compares medical data with a sound Christian anthropology. He adds that the neurological criterion – complete and irreversible cessation of all brain activity – does not seem to conflict with the essential elements of a sound anthropology if it is rigorously applied, and that health workers can use it to reach the kind of assurance that moral teaching calls moral certainty. The careful phrasing and the explicit emphasis on moral certainty show that this is a prudential, conditional acceptance, not a definitive endorsement of a particular medical standard.

Divergent Catholic Positions. The Catholic reception of DNC has developed along roughly three lines. First, some theologians and bishops' conferences offer confident acceptance. They hold that neurological criteria, when rigorously applied, offer adequate moral certainty of death and emphasise papal encouragement of organ donation and decades of clinical practice.

Second, others offer fundamental critique.[11] They argue that the empirical and conceptual difficulties – especially those highlighted by integrative unity and

[11] David Albert Jones, "Loss of Faith in Brain Death: Catholic Controversy over the Determination of Death by Neurological Criteria," *Clinical Ethics* 7, no. 3 (2012): 133–141, https://doi.org/10.1258/ce.2012.012m07.

hypothalamic function – undermine the reliability of DNC. They claim that continued retrieval of vital organs from brain-dead patients involves a real risk of killing living persons and call for moratoria or a return to purely cardiopulmonary criteria.

Third, a middle group adopts cautious acceptance and reform. They regard DNC as possibly compatible with Catholic anthropology but insist on tighter diagnostic protocols, greater transparency about residual uncertainty, and robust protection for conscientious refusal. This article broadly aligns with the third position.

5. Moral Certainty, Prudence, and the Option for the Vulnerable

In light of the requirement of moral certainty, three practical conditions become crucial in the context of organ donation. First, conceptual adequacy: the criteria used (neurological or circulatory) must correspond to a reasonable and coherent philosophical understanding of death as the irreversible loss of the organism's capacity for self-integration. Second, empirical reliability: clinical protocols must be robust enough that the risk of misdiagnosing a living person as dead is remote, not merely non-zero. Third, integrity of decision-making: the process by which death is determined must be insulated from conflicts of interest – especially the desire to obtain organs.

Preferential Option for the Vulnerable in Global and Regional Context. The preferential option for the poor has both a global and a regional dimension. Worldwide, organ shortages are severe, and in many countries a significant percentage of patients on transplant waiting lists die before receiving an organ. This creates constant pressure to expand donor pools.

At the same time, reports from international bodies indicate that organ-exporting countries are often located in parts of Africa, Asia, Eastern Europe, and South America, where weaker regulatory systems and poverty make vulnerable populations susceptible to exploitation.[12] Lithuania and other Eastern European countries, where transplant programmes are growing and public campaigns encourage donation, illustrate both the potential and the pressure.[13]

In such a landscape, the option for the vulnerable implies that any residual doubt about whether a donor is dead must be resolved in favour of the potential donor, not of the transplant programme. The poor, the medically illiterate, and families under acute emotional stress must not bear the weight of systemic shortages. A Catholic ethic cannot justify risking the life of even one uncertain donor for the sake of aggregate transplant statistics.

[12] United Nations Office on Drugs and Crime (UNODC), *Global Report on Trafficking in Persons 2024* (Vienna: UNODC, 2024), accessed December 3, 2025, https://www.unodc.org/documents/data-and-analysis/glotip/2024/GLOTIP2024_BOOK.pdf.

[13] "Lithuania – European Capital of Organ Donation 2024: We Invite You to Build Bridges for Life," Lithuanian National Transplant Bureau, May 2, 2024, accessed December 3, 2025, https://ntb.lrv.lt/en/news/lithuania-the-capital-of-organ-tissue-and-cell-donation/.

6. Toward a Catholic Ethic of Cautious Generosity

The first task is to reaffirm the goodness of organ donation. In a context where mistrust and conspiracy theories abound, the Church has a role in proclaiming that freely given bodily donation – once death is certain – can be a beautiful participation in Christ's self-gift and an expression of the communion of saints.

Second, Catholic ethics should advocate for stronger diagnostic standards and clearer laws. Concretely, this might include requiring at least two independent physicians to confirm death, one of whom is a specialist in neurology or intensive care and neither of whom is part of the transplant team; mandating strict apnoea testing protocols – apnoea testing being the bedside procedure that checks for the absence of spontaneous breathing – with well-defined physiological preconditions; using ancillary tests whenever clinical examination is incomplete; and establishing clear minimum observation times both for DNC and for DCD.

6.1 Realism about Resources

At the same time, a realistic note is necessary. In low-resource settings, equipment for ancillary testing or continuous monitoring may be limited. Staffing patterns may not allow for multiple independent assessments, especially at night or in smaller regional hospitals. A Catholic ethic of cautious generosity should still present high standards as regulative ideals, while encouraging incremental steps that increase reliability even when full protocols are not yet feasible. The basic requirement remains constant: where moral certainty cannot be achieved, the presumption must favour the continued life of the donor.

6.2 Communication, Consent, and Conscience

The Church should encourage transparent, honest communication with patients and families, explaining in accessible language what DNC and DCD are; clarifying that organ retrieval is considered only after death has been declared; acknowledging that within the Catholic community there is ongoing debate about these criteria; and ensuring that consent to donation is always free and that refusal carries no moral stigma. Such transparency may reduce the number of donations in the short term, but it increases trust in the long term.

Ecclesial institutions and Catholic bioethics guidelines should explicitly protect conscientious refusal. Individuals should be able to register as donors while specifying limits; families should be supported if, in conscience, they decline organ donation because they lack moral certainty; and healthcare professionals with serious reservations about DNC or certain DCD protocols should not be coerced into participation.

7. Pastoral and Ecclesial Implications

The questions raised in this article are not confined to ethicists and transplant teams. They shape the daily ministry of pastors, hospital chaplains, catechists, and future deacons and priests, including in countries where transplant programmes are rapidly developing.

First, formation. Seminaries, diaconal programmes, and lay formation courses should include structured modules on end-of-life ethics, organ donation, and the Catholic understanding of death. These modules might use realistic case studies – for example, a priest called to the ICU of a university hospital where a young man has been declared brain dead and the transplant coordinator is waiting outside; or a rural parishioner with heart failure on the waiting list for a transplant whose family feels guilty about needing someone else to die. Discussing such cases helps future ministers move beyond slogans toward careful moral discernment.

Second, accompaniment. Hospital chaplains and parish clergy need pastoral tools to accompany families at the bedside. This includes developing a simple way of explaining the difference between medical signs of death and the theological language of the soul's departure; providing specific prayers and blessings for situations involving organ donation; and offering follow-up accompaniment so that families do not feel that their loved one's body was handled purely technically.

Third, public witness. Catholic hospitals and healthcare systems can bear public witness by publishing their policies on death determination, conflicts of interest, and donor protection in a transparent, accessible form; affirming in their organ donation information materials that they follow the highest available standards and that donors' and families' rights are protected; and participating in national and European debates about transplant legislation and anti-trafficking measures,[14] grounding their contributions both in medical evidence and in the Church's social teaching on human dignity and the common good.

Conclusion: Between Fear and Indifference

The controversy over brain death, DCD, and organ donation exposes a deep tension in contemporary medicine: we possess extraordinary power to sustain and redistribute bodily life, yet we remain fragile, mortal beings whose dying cannot be reduced to a

[14] Council of Europe, "Council of Europe Convention against Trafficking in Human Organs (CETS No. 216)", Santiago de Compostela, March 25, 2015, accessed December 3, 2025, https://rm.coe.int/16806dca3a; and Council of Europe, "Explanatory Report to the Council of Europe Convention against Trafficking in Human Organs (CETS No. 216)", accessed December 3, 2025, https://rm.coe.int/16800d3840.

technical parameter. Transplant medicine stands where high technology, economic interests, and raw human vulnerability intersect.

Catholic ethics must steer between two temptations: fear, which retreats from organ donation altogether as if every transplant were intrinsically suspect; and indifference, which treats definitions of death as adjustable variables in a technocratic system, so long as waiting lists shorten and transplant numbers rise.

An ethic of cautious generosity charts a different path. It affirms organ donation as a privileged form of Christian charity, rooted in a theology of the body and the communion of saints. It insists that donors must truly be dead before vital organs are removed. It acknowledges real uncertainties about DNC and DCD and calls for diagnostic and legal reforms, transparency, and meaningful oversight. It protects the consciences of families and professionals who, in good faith, cannot achieve moral certainty in particular cases.

For countries where transplant programmes are expanding and international scrutiny of trafficking and inequality is intense, this ethic offers a way to harness medical progress without sacrificing the dignity of the weakest. The Church's role is not merely to bless existing systems but to accompany, question, and sometimes resist them, so that the lives and deaths of donors and recipients alike are honoured.

"You only die once." In the end, this is not a slogan against transplantation but a reminder that the passage from life to death deserves our highest reverence. That reverence will be preserved only if technical expertise and the deepest questions of human dignity remain in constant, respectful dialogue.

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Ersun Augustinus KAYRA is an independent Catholic writer and researcher based in Istanbul, Turkey. He studied theology and Christian leadership at Dallas Theological Seminary, US (M.A. in Christian Leadership). His main areas of interest are Catholic moral theology and bioethics (especially organ donation, brain death, and end-of-life ethics), ecclesiology and synodality, and the intersection of Catholic social teaching with urban life, migration, and vulnerability. E-mail ersunaugustinuskayra@gmail.com.

Ersun Augustinus KAYRA – nepriklausomas katalikų rašytojas ir tyrėjas, gyvenantis Stambule, Turkijoje. Studijavo teologiją, įgijo krikščioniškosios lyderystės magistro laipsnį Dalaso teologijos seminarijoje (JAV). Pagrindinės interesų sritys – katalikų moralinė teologija ir bioetika (ypač organų donorystė, smegenų mirtis ir gyvenimo pabaigos etika), ekleziologija ir sinodalumas, taip pat katalikų socialinio mokymo sąsajos su miesto gyvenimu, migracija ir pažeidžiamumu. El. paštas ersunaugustinuskayra@gmail.com.